Rev. 10/08

2009 Retiree Enrollment / Change Form

I. Personal Information – please print all information

Retiree Name _____ Gender _____ SSN _____
(Last Name, First Name)

If Surviving Spouse, Name _____ SSN _____

Address: _____ (_____) _____
Street Apt# Phone

_____
City State Zip E-mail address

II. Retiree & Dependent Information (Complete this section for any change in coverage or new enrollments.)

Relationship and Plan	Last Name, First Name	Birthdate	Social Security No.	Eff. Date
❍ RETIREE ❍ Medical ❍ Dental ❍ Vision				
❍ SPOUSE ❍ SURVIVING SPOUSE ❍ Medical ❍ Dental ❍ Vision				
❍ DAUGHTER ❍ SON ❍ OTHER ❍ Medical ❍ Dental ❍ Vision				
❍ DAUGHTER ❍ SON ❍ OTHER ❍ Medical ❍ Dental ❍ Vision				

III. UnitedHealthcare Dental plan Place an "X" in the appropriate box below:

Plan	Retiree Only	Retiree and one dependent	Retiree and two or more deps.
DHMO	❍ $11.18	❍ $18.44	❍ $27.26
PPO Low	❍ $11.78	❍ $23.34	❍ $41.08
PPO High	❍ $28.41	❍ $56.27	❍ $99.04

* I decline DENTAL coverage for: ❍ myself ❍ my spouse ❍ my dependent children
due to: ❍ Existence of other coverage ❍ Don't want/need

IV. UnitedHealthcare Vision plan Place an "X" in the appropriate box below:

Plan	Retiree Only	Retiree and one dependent	Retiree and two or more deps.
Vision Plan	❍ $6.12	❍ $12.85	❍ $19.58

* I decline VISION coverage for: ❍ myself ❍ my spouse ❍ my dependent children
due to: ❍ Existence of other coverage ❍ Don't want/need

Definitions for Sections V through VII:

Coverage Level: Retiree Only, Retiree + Spouse, Retiree + Child or Children, or Retiree + Family

Years of Service: 10-14, 15-19, 20-24, 25-29, or 30 & Over **for retirement dates before January 1, 2008**

Years of Service: 10, 11, 12, … 29, or 30 & Over **for retirement dates after December 31, 2007**

Retiree Medical / Pharmacy Plan Options

REMINDER: The city contribution toward retiree medical coverage is based on:
• Date of retirement **prior to January 1, 2008,** OR • Date of retirement **after December 31, 2007**

What was your year of retirement? _____. Refer to the 2009 Monthly Retiree Rate chart that applies to your year of retirement to correctly calculate your monthly cost for coverage.

V. Under Age 65 Plan Enrollment – UnitedHealthcare Medical & Rx Plan

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ Value Medical & Rx	_____	_____	_____
❍ Core Medical & Rx	_____	_____	_____
❍ Plus Medical & Rx	_____	_____	_____
❍ Premium Medical & Rx	_____	_____	_____
❍ *Decline Coverage			

VI. Age 65+ Plan Enrollment – Medicare Advantage or AARP Supplement Plan

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ Secure Horizons with Rx	_____	_____	_____
❍ AARP K Supplement	_____	_____	_____
❍ AARP F Supplement	_____	_____	_____
❍ AARP J Supplement	_____	_____	_____
❍ *Decline Coverage			

* I decline MEDICAL coverage for: ❍ myself ❍ my spouse
due to: ❍ Existence of other coverage ❍ Don't want/need

Coverage Level:
Retiree Only
Retiree + Spouse
Retiree + Child or Children
Retiree + Family

Years of Service, retirement before 1.1.08:
10-14, 15-19, 20-24, 25-29, 30 & Over

Years of Service, retirement after 12.31.07:
10, 11, 12, ... 29, or 30 & Over

VII. Age 65+ Pharmacy Plan Enrollment – UnitedHealthcare Medicare Part D Rx Plan

(Must be enrolled in one of the AARP supplement plans to enroll in the UHC Medicare Part D plan.)

Plan	Coverage Level	Years of Service	Your Monthly Cost
❍ UHC Medicare Part D	_____	_____	_____
❍ *Decline Coverage			

* I decline MEDICARE PHARMACY coverage for: ❍ myself ❍ my spouse
due to: ❍ Existence of other coverage ❍ Don't want/need

NOTE: If you are currently enrolled in the city provided UHC Medicare Part D plan and you subsequently decline this coverage, you must complete a UnitedHealth Rx Part D – Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage form and return to Workforce Services, P.O. Box 90231 MS 63-0790, Arlington, TX 76004-3231 by 12/31/08, along with this form.

VIII. Monthly Cost Payable to City of Arlington Insurance

$_____ + $_____ + $_____ + $_____ + $_____ = $_____
Dental Vision Under 65 Medical Secure Horizons Medicare Part D Total Payable to City

IX. Monthly Cost Payable Directly to AARP

(must complete this form and an AARP enrollment form to become enrolled in plan K, F or J Medicare Supplement plan). AARP determines your final monthly cost. The City's rates are estimates based on a 5% increase scheduled for April 1, 2009.

Estimated Monthly Cost Payable to AARP = $_____

X. Retiree and Spouse Signature Required

_____ _____
Retiree Signature Date Spouse Signature Date

* Failure to complete decline statement may disqualify you for 31 day Special Enrollment Rights (please check all applicable items).